KAISER PERMANENTE®

Kaiser On-the-Job®

MR #: _____

Name: _____

INITIAL INDUSTRIAL VISIT QUESTIONNAIRE

To be completed by the injured worker at the initial visit for an industrial injury or illness

PLEASE PRINT

IMPRINT AREA

YOUR INFORMATION

LAST NAME	FIRST NAME	SEX ☐M ☐F	BIRTH DATE	SOCIAL SECURITY #

HOME ADDRESS	CITY	STATE, ZIP

HOME PHONE	OTHER PHONE	WORK PHONE

JOB TITLE OR DESCRIBE THE TYPE OF WORK YOU DO	ARE YOU A LONGSHOREMAN? ☐Yes ☐No

EMPLOYER INFORMATION

COMPANY NAME	SUPERVISOR/CONTACT	SUPERVISOR/CONTACT PHONE

ADDRESS	CITY	STATE, ZIP

ABOUT YOUR INJURY OR ILLNESS

WHERE WERE YOU WHEN YOU BECAME INJURED OR ILL? (LOCATION, IF DIFFERENT FROM YOUR EMPLOYER'S ADDRESS)

DATE YOU WERE INJURED OR BECAME ILL	TIME ☐AM ☐PM	MOST RECENT DATE WORKED

HAVE YOU REPORTED THIS AT WORK? ☐Yes ☐No	ALL INJURED WORKERS MUST COMPLETE THE EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS (FORM DWC-1). HAVE YOU COMPLETED AND RETURNED THE FORM TO YOUR EMPLOYER? ☐Yes ☐No

HAVE YOU SEEN A KAISER DOCTOR FOR THIS INJURY OR ILLNESS? ☐Yes ☐No

HAVE YOU SEEN ANY OTHER DOCTOR FOR THIS INJURY OR ILLNESS? ☐Yes ☐No IF YES, WHERE?

HOW DID YOU BECOME INJURED OR ILL? DESCRIBE HOW IT HAPPENED AND WHAT PART(S) OF THE BODY ARE AFFECTED

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

SIGNATURE	DATE SIGNED

FOR OFFICE USE ONLY: INSURANCE VERIFICATION